DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

November 13, 2017

Ms. Allyson Sweeney, Manager The Residence At Shelburne Bay East 185 Pine Haven Shores Road Shelburne, VT 05482-7805

Dear Ms. Sweeney:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on October 3, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN

imlaMCotaBN

Licensing Chief



NOV 02 2017

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING. B. WING		(X3) DATE SURVEY COMPLETED C 10/03/2017	
VAME OF F	PROVIDER OR SUPPLIER	STREET AF	INDESS CITY S	TATE, ZIP CODE	, , , , , , , , , , , , , , , , , , ,	
WING OF F	NOVIDEN ON SOFFEIEN		HAVEN SHO	•		
THE RES	IDENCE AT SHELBU	RNE BAY FAST	RNE, VT 054			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETE	
R100	Initial Comments:		R100			
	from 10/2/17 - 10/3 Licensing and Prote mandated self repo no regulatory violati	n-site survey was conducted /17 by the VT Division of ection to investigate a facility rt and complaint. There were ons related to the self-report. atory violation is from the				
R297 SS=E	IX. PHYSICAL PLANT 9.9 Ventilation		R297	Effective immediately, painting, renovalions or improvement projects T	apital	
				at Shelburne Bay will im pre-planning meeting wil	olement a	
	9.9.a Homes shall be adequately ventilated to provide fresh air and shall be kept free from]	and our multi-disciplinary	team to	
	smoke and objectionable odors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assure that all spaces within the footprint of the building (the Assisted Living Residence (ALR)), were adequately ventilated at			review all safety and ver questions and concerns.		
1				include a thorough review	of all SDS	
-			1	sheets and safety recom		
ĺ				We will put proper precat		
			1	measures in place and ke resident and associate s		
				highest priority. The Admi		
Ì		hat there was sufficient fresh		monitor for compliance.	11101121101 44111	
į	air and that the area			•		
ļ		. This failure had the potential			\$ -	
	to affect multiple and include:	eas of the building. Findings	.			
	molade.					
-		nsing and Protection received				
		to the existence of potentially				
		e building during the 4 day]	•		
		r, 2017, when the indoor pool				
	painting was being completed. It was reported that the fumes were overwhelming in the second					
		room, which includes a				
		it. The complaint stated that				
	overwhelming smell	Ifumes caused some persons				
	to experience head:	aches, blurry eyes and other	i i			

Division of Licensing and Protection							
STATEME	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		1009	B. WING		•	C 03/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY.	STATE, ZIP CODE			
		185 PINE	•	DRES ROAD			
THERE	SIDENCE AT SHELBU	RNE BAY EAST SHELBUR	RNE, VT 054	82			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
R297	Continued From pa	ge 1	R297			5	
.*	symptoms, mostly o	on the second floor of the				;	
31	facility. The compla	int alleged that the facility					
		action to immediately mitigate				3	
		nd Initiate a plan to adequately				<u> </u>	
		d areas. During interviews e staff person stated that a					
W.		e stati person stated that a sined to them of dizziness.	<u> </u>		•	a de decembra	
	Some staff reported	that they had experienced					
i.		ches and other symptoms. (It					
1		it the residents on this unit	ļ				
		irments and may not have the				, ne	
•	ability to express ar	y concerns clearly.)				1	
	The pool is located	on the first floor of the building					
		m a hallway, via a set of				-	
* *		en a set of double steel doors.					
		ea and heat/air exchange					
1		m Director of Maintenance					
3		oming of 10/2/17. Per					
		pool room (2 stories in height) e room (energy recovery unit)					
		the ventilation duct system		•			
1		ir exchange system in this				Total de la companya	
6 8' 5		ducts located in the pool		•			
		in from the outside, through				ļ	
(and into the air exchange				1	
<i>!</i>		e air ducts re-enter the pool					
÷.		rough the pool room wall to of room had fixed windows				:	
		de wall, with no direct way to					
		ne outside directly. A wall vent					
	оп an inside wall wa	s observed high up on the					
		en asked if that vent was					
		tion of painting, the staff didn't					
	Know the answer, si	nce they stated that they					
		the ventilation plans. The pool ntracted painting company.				j	
}	was hanned by a co	лиастео ранину сотрану,					
1	During interviews wi	th facility leadership staff					
		at were taken in response to				1	

Division	of Licensing and Pro	otection				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		1009	B. WING		1	C 03/2017
					1 10/1	0312011
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		•
THE RE	SIDENCE AT SHELBU	RNE HAY FAST	HAVEN SHO RNE, VT 0540			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETE DATE
R297	Continued From pa	ge 2	R297			:
	the painting, there we maintenance. It was Director of Maintenance is was Director of Maintenance in Maintenanc	rey stated that at the time of was an Interim Director of a stated that the previous ance and the owner's of Operations handled the nting of the pool job. When role was in planning for the sterim Director said he wasn't uning for the project. Staff cook 4 days and during that recovery unit was turned off to entering the ventilation tive Director stated that 'there strong' for the 1st two floors and in the hallways. The room had a very strong fumes and the residents were om for dining for some of the enterior stated the painters of the product Safety Data anufacturer for the 2 d. Per review, the products should only be used in well divapors can cause symptoms, dizziness and other	A particular de la constanta d			
	During interview with representative of the 10/3/17 at 11:30 AM when using these 2 all ducts, outlets, do the room being paint of the painting complete confirmed that there for the safe ventilating painting of the pool, were responsible for	h an environmental e manufacturing company on I, s/he stated that precautions products include: sealing of pors etc. and a need to vent ated to the outside. The owner pany was contacted and e was a shared responsibility on of the area during the S/he stated that their staff or sealing off the double sets of the to the pool (on the first				

Division of Licensing and Protection							
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
,		1009	B WING		C 10/03/2017		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
THE RES	SIDENCE AT SHELBU	NNE HAY FASI	HAVEN SHO				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT DF OEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE COMPLETE		
R297	Continued From pa	ge 3	R297				
	and control of the a building. The owne his staff who compl information was pla	cility, due to their management in handling system for the r stated that he confirmed with eted the job that this nned and exchanged with the ance prior to the start of the		, .			
	present for over 24 additional measures odors and fumes, b fans for the ducts, to the outside; however days to completely of this time, staff were	fumes/vapors had been hours, the facility took is to attempt to remove the sy setting up reverse action o draw the indoor pool air to er, the process took several eliminate the issue. During caring for residents and ort, per the Executive Director.					
The second secon	about their responsing painting of the pool objectionable odors areas in limited loca an extended period exhaust/remove the staff and involved period.	eodors, per interviews with ersons/professionals as well he building, including part of	The state of the s				
Representation to the control of the							